

A Report on the Progress of Connecticut's Primary Care Case Management Pilot Program

HUSKY Primary Care

- What is PCCM?
- Implementation, Year One
 - Provider recruitment
 - Client information/education
 - Roll out of pilot sites
 - Development of protocols and quality improvement – Provider Advisory Group
 - Data analysis/evaluation
- Plans for the Future
- Lessons Learned

Legislative Mandate for PCCM

- Section 16, Public Act No. 07-2, June Special Session:
 - the Commissioner of Social Services will initiate “a primary care case management pilot program of not less than one thousand individuals who are otherwise eligible to receive HUSKY Plan, Part A (Medicaid managed care) benefits.”

PCCM requirements under 1915(b) waiver (for Medicaid managed care)

- Pursuant to the terms of the amendment to its 1915 (b) Medicaid Managed Care Waiver (HUSKY A), the Department of Social Services was further directed to implement the following changes to the Primary Care Case Management (PCCM) Pilot Program:
 - PCCM shall be operational in the Greater New Haven and Greater Hartford areas no later than January 1, 2010.
 - The Commissioner of Social Services shall commission an independent evaluation of the cost, quality, and access impacts of the PCCM programs in Waterbury and Windham by July 1, 2010 and shall submit the evaluation to the Human Services and Appropriations Committees. The Commissioner shall identify any deficiencies in the program and recommend remediation measures.
 - PCCM shall be operational in additional geographic areas that the Commissioner approves after July 15, 2010 provided: (A) the independent evaluation finds that the PCCM program is successful in containing costs and improving quality and access; and (B) an adequate number of primary care physicians (PCP's) for both children and adults have submitted applications with the Department of Social Services.
 - New PCPs shall be allowed to enroll in PCCM at any time in any geographical area where PCCM is in effect.
 - The Department of Social Services shall inform HUSKY A enrollees in approved geographic areas of the availability of PCCM to the same extent that the Department informs such enrollees of the ability to enroll in a Managed Care Organization.
 - For purposes of this amendment, “geographical area” means Hartford, New Haven, Waterbury, and Windham, and towns that are contiguous to said cities.
 - The Department of Social Services will report to the Human Services and Appropriations Committees on the status of the PCCM program on January 1, 2010.

What is PCCM?

- **Primary care case management** means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid recipients.
- **Primary care case manager (PCCM)** means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:
 - (1) A physician assistant.
 - (2) A nurse practitioner.
 - (3) A certified nurse-midwife.

What is PCCM?

- PCCM is managed care without the managed care organization
- Clients enroll with a provider, rather than an MCO
- The provider receives a \$7.50/member/month payment (in addition to fees for clinical services) to provide care coordination
- It is not a Patient-Centered Medical Home model, but is striving to get there

Implementation, Year One

- **Provider recruitment**
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Provider Recruitment

- “Wide net” recruitment effort
 - Professional groups and associations
 - Trade groups
- Targeted provider outreach
 - AAP “Lunch and Learn”
 - Academic and hospital department presentations
 - Regional medical societies
- Formal provider forums
 - New Haven and Hartford (October, 2008)

Provider Recruitment

- Eligible providers
 - Primary care providers
 - Physicians – pediatricians, internists, family physicians, obstetricians, and in some cases, specialists
 - Nurse Practitioners
 - Certified Nurse Midwives
 - Physician Assistants under the direction of a physician
- Need to care for family 'assistance units' – must have providers for both children and adults

Provider Recruitment

- Regional pilot sites (to be described)
 - Waterbury – 41 providers from 2 private pediatric practices, StayWell Health Center and the Franklin Medical Group
 - Windham – 13 providers from 2 private pediatric practices and the Generations Family Health Center
 - Hartford – 49 providers from the Burgdorf/Bank of America Health Center, East Hartford Community HealthCare, Community Health Services, Inc., the Charter Oak Health Center (excluding their CCMC site), and the Family Medicine Center at Asylum Hill
 - New Haven – 125 providers from the Cornell Scott-Hill Health Center, Fair Haven Community Health Center, the Primary Care Centers at Yale/New Haven Hospital, and 4 private pediatric practices

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Client information/education

- Member notices –
 - Direct marketing with over 52,000 notices to clients announcing the available 4th option
 - Ongoing inclusion in mailings to newly eligible HUSKY A clients as a 4th HUSKY health care option
- HUSKY Primary Care brochure and signs – provided to providers for their office, as well as DSS offices
- Comparison chart - “Tips on Choosing a HUSKY A Option”
- Department websites (www.huskyhealth.com)

Implementation, Year One

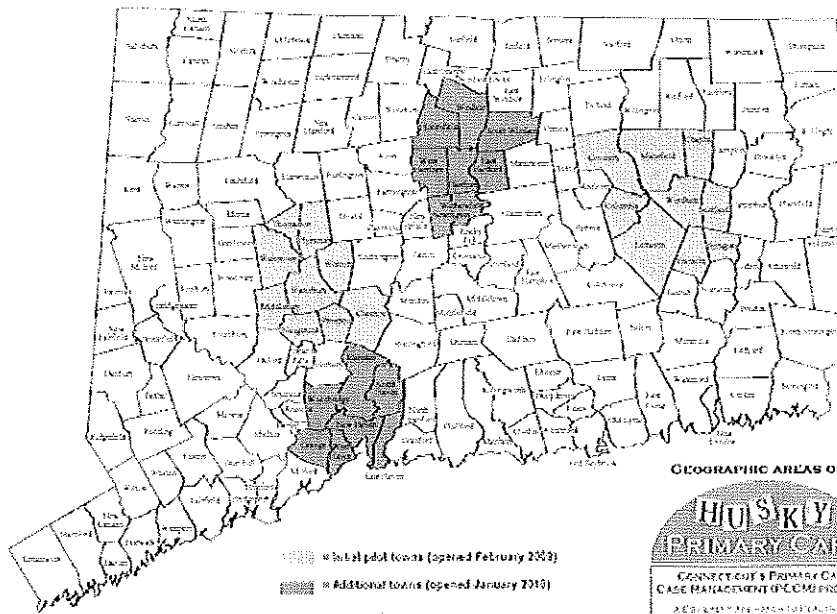
- Provider recruitment
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Roll Out of Pilot Sites

- PCCM was rolled out in stages
 - Existing patients of participating Waterbury and Windham practices – February 1, 2009
 - All eligible clients living in Waterbury, Windham and their contiguous towns – July 1, 2009
 - Hartford, New Haven and contiguous towns – January 1, 2010
- Why gradual?
 - Provider fears of deluge of new Medicaid patients
 - Allow providers to get comfortable with new case management responsibilities
 - Following legislative amendment to 1915(b) waiver

Roll Out of Pilot Sites

- Outreach to providers
- Provider applications, contracting, and review; enrollment in Title 19/Medicaid, if needed
- Speaking and meeting with interested providers, working with them on new requirements and program-specific items (for example, accessing monthly client roster)
- Systems setup
 - Each PCP is set up in both our MMIS and in our client enrollment system as if they are a new "health plan"
- Creating and sending new notices and brochures to all HUSKY clients
- Additional information and/or training to DSS staff, other entities (ACS, HUSKY InfoLine, community organizations, etc.)



Overall HUSKY A population in HUSKY Primary Care pilot areas

	HUSKY A population	% total statewide HUSKY A enrollment
Original Pilot Areas (as of 2/1/09):		
Windham/Willimantic Area	8,075	2.3%
Waterbury Area	36,444	10.3%
New Areas (as of 1/1/10):		
New Haven Area	44,244	12.5%
Hartford Area	57,331	16.2%
Total across all four areas	146,094	41.2%

* Based on October 2009 enrollment

Implementation, Year One

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- **Development of protocols and quality improvement – Provider Advisory Group**
- Data analysis/evaluation

Provider Advisory Group

- Key component of successful models in other states
- Volunteer providers from practices around the state interested in participating – do not have to be from participating sites
- Developed practice guidelines, disease measures, methods and mechanisms of data reporting

Provider Advisory Group - subcommittees

- Care Coordination – Sandra Carbonari, Chair
 - Developed recommendations for patient risk assessments, structured care plans
 - Training for practices on both risk assessment and care plans
- Disease Management – Nancy Quimby, APRN, Chair
 - Disease management protocols for children's asthma, adult onset diabetes, obesity in all age groups
 - Recommended disease-specific outcomes measures
- Data Collection/Evaluation – Marjorie Berry, Chair
 - Recommended data to be reported, data reporting formats and reporting tool
 - Recommendations on claims-based reporting measures

Implementation, Year One

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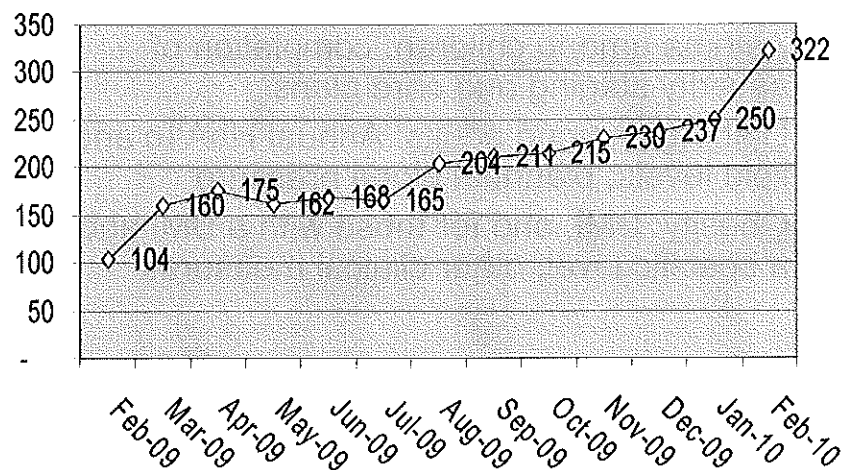
Data analysis/evaluation

- Provider reported measures, based on Provider Advisory Group:
 - Completion of a risk assessment and care plan
 - Asthma among children: completion of severity staging and care plans
 - Diabetes among adults: Annual HbA1c and lipid levels; biannual blood pressure
 - Obesity: BMI, and for those with a BMI above a specific level, other clinical measures

Data analysis/evaluation

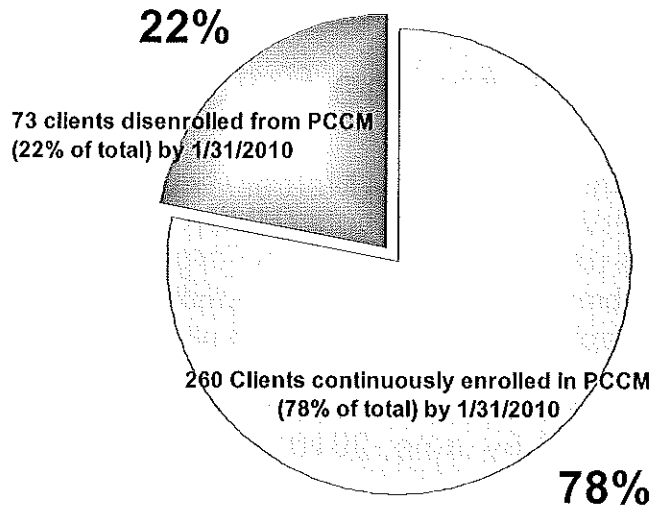
- Shorter-term, including:
 - Immunization, inpatient and emergency department utilization (generally, and related to asthma or diabetes), preventive and well-care, asthma medications, developmental screening, EPSDT screening and participation ratios, outpatient drug utilization
- Longer-term, including:
 - Breast and cervical cancer screening, antibiotics for upper respiratory infections among children, antibiotics for bronchitis among adults

HUSKY Primary Care Enrollment: Feb. 2009 to Feb. 2010



Husky Primary Care: Enrollment & Disenrollment

333 Total Unduplicated Enrollees in HPC as of 1/31/2010



HUSKY Primary Care: Disenrollment & Destination

Length of Enrollment in PCCM	Total Disenrollment = 73	Destination	
		MCO	Lost Eligibility
1 - 2 months	33 [45% of Total 73]	31	2
3 months and more	40 [55% of Total 73]	18	22

- 9 clients subsequently re-enrolled in to PCCM after losing eligibility and being re-instated into HUSKY

Plans for the Future

- Independent evaluation – Mercer Government Human Services Consultants (HUSKY Program's external quality review organization)
 - To be submitted to the General Assembly in July
 - Specific proposal/specifications currently being reviewed
- Continued growth of client enrollment (budget assumes 1,150 by June, 2010 and 3,000 by June, 2011)
- Continuation of data collection and analysis – claims-based and provider reporting
- Possible further expansion state-wide depending upon results of evaluation

Lessons Learned

- HUSKY Primary Care is a pilot
- Generally, other states with successful PCCM programs (such as North Carolina and Oklahoma):
 - Set them up over several years
 - Surround them with significant infrastructure and resources in addition to the case management fee
 - Pay providers FFS rates which equal or approach Medicare fees

Lessons Learned – from PCPs

- PCCM is a new concept that is hard to explain to providers (and much harder to explain to consumers)
- Pediatricians are generally committed to Medicaid, HUSKY, and care coordination; internist and family physician buy-in is more challenging
- Access to PCPs for adults is a problem (not just in Medicaid)
- Many practices do not offer after hours and weekend access to care
- Few PCP offices have successfully implemented Electronic Medical Records
- Many providers do not have the staff, expertise, and time to collect data

Lessons Learned - from specialists

- Access to some specialty care under Title XIX is limited in some areas
- Physicians feel enrollment in Title XIX is cumbersome and may be a barrier to access to care
- Many specialists provide services which they feel PCPs should provide
- Many obstetricians do not wish to take on many of the responsibilities of PCPs
- Coordination of care between specialists and PCPs needs improvement

Lessons Learned – from clients

- Many like, or at least are comfortable with, the HUSKY MCOs
- Trusting their PCP to take the place of an MCO requires a leap of faith, especially with a new program
- Specialty care, especially outside of major teaching hospitals, is a concern
- Many who ask their PCP if the care they receive under HUSKY Primary Care will be different from what they get with them under an MCO are told “no”

Lessons Learned – from DSS

- Our systems are well-designed for managed care and less-so for a different model
- System changes to support PCCM will require already scant resources to be taken from other priorities
- While necessary, meeting with providers' offices and staff is time-consuming, inefficient
- Collecting data, enrolling providers, and otherwise managing a 4th coverage option requires considerable DSS staff resources and is very time consuming

Lessons Learned – Main Barriers to Broader Expansion

- Access to PCPs for both adults and children
- Access to Title XIX specialists
- Systems, resources, administrative services capabilities
- Still a learning experience; effects on patient care and costs in Connecticut still unclear

Lessons Learned

We have a community of care givers, advocates, legislators, contracted vendors, DSS staff members, and others who care deeply about the services provided to our clients.

TESTIMONY to the Appropriations Committee
February 5, 2010

Re: Why Connecticut needs Primary Care Case Management

Ellen Andrews, PhD
Executive Director

Primary Care Case Management (PCCM) is a way of running Medicaid managed care used successfully by thirty other states. PCCM does not involve HMOs and serves as an important alternative to HMOs in contracting and providing access to care. In PCCM, consumers are linked to a Primary Care Provider who coordinates their health care. Providers are paid on a fee-for-service basis, and receive additional dollars to compensate for care management responsibilities. Providers are not at financial risk for the services they provide or authorize. PCCM is a form of the patient-centered medical home model, featured in both national health reform bills. The medical home model has been adopted by Medicare, most large private payers, and features prominently in the CT Comptroller's plan for the new state employee plan contracts.

The current HMO-based HUSKY program is deeply troubled, has been for its entire tenure, and is not improving. HMOs have received 24% rate increases; an independent audit commissioned by the Comptroller's Office last year found \$50 million in overpayments. In 2007, barely half of HUSKY children received scheduled check ups, and over one in ten did not get any health care at all from the program. In a 2007 secret shopper survey, trained surveyors posing as HUSKY clients were only able to secure an appointment for care with one in five providers listed by the HMOs; that survey has not been repeated and DSS has no plans to do so. Few CT providers accept HUSKY, while other states' participation rates are far higher, including states with less generous rates for services. Providers report that the hassles of dealing with HMOs are a significant barrier to HUSKY participation.

We were very pleased to see in the Governor's budget document Wednesday a proposal to move the HMOs from capitation to a non-risk Administrative Services Organization (ASO) model of financing. While this shift would, if approved, remove one clear economic incentive for HMOs to deny care, it does not address many other problems in the current program. Some of those problems include administrative hassles, a lack of responsiveness to provider or consumer feedback, little or no experience with care coordination, contentious relationships with providers, resistance to accountability, and little transparency in either data collection or finances. I am gratified to see that the administration now recognizes the financial toll HMO capitation has placed on taxpayers, estimated at \$28.8 million for FY 2011, and plans to capture those savings in the future.

When Oklahoma switched from HMOs to PCCM in 2004, the state saved \$85.5 million in medical costs in the first full fiscal year and the number of participating providers increased.

by 44%. They found that outpatient visits went up and ER visits went down. After PCCM, quality of care improved in 14 of 19 standardized measures including check ups for children, appropriate asthma medications, and dental care.

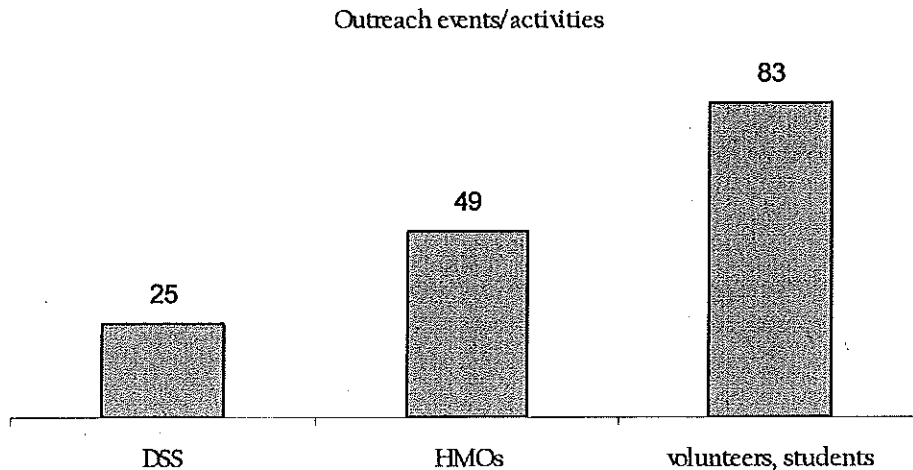
CT needs an alternative to HMO-based administration for HUSKY. Without a viable alternative, both HUSKY families and taxpayers are held hostage to whatever rate increases, including administrative costs, the HMOs demand. Because there is no HMO between the state and families, PCCM affords the state better transparency in tracking both finances and care utilization. States with PCCM programs have found equal or better patient satisfaction levels. The core of PCCM, care coordination, supports the patient-provider relationship that is the basis of good care.

Unfortunately implementation of PCCM in CT has been problematic. Despite passage of PCCM into law three years ago, requiring among other things enrollment of at least 1,000 HUSKY members, a year after implementation the program has only 253 consumers. Advocates have struggled to overcome many challenges created by DSS including limiting provider applications to a very short application timeframe, only allowing enrollment of current patients of those providers, refusing to print brochures for providers or consumers, and reversing agreements with the advocate/DSS working group and limiting the program to only two small communities. The lack of resources for marketing PCCM, especially compared to the resources allowed to HMOs, has been a particular problem. It has taken enormous effort on the part of advocates to overcome each of these artificial barriers imposed by DSS including media coverage, legislative, and administrative advocacy at both the state and federal levels.

Despite this extraordinary level of advocacy, many challenges remain unresolved. DSS has repeatedly refused to remove the inappropriate and unnecessary requirement that PCCM providers agree to Freedom of Information constraints. This requirement is irrelevant and intimidating to providers and has served as a barrier to participation. Notably, providers in the HMO system are not subject to this requirement. When the two new HMOs complained that they needed to build their membership to be financially sustainable, DSS granted them default status until they reached their target. However, DSS has refused to grant a similar policy for PCCM.

In response to concerns about the unfairness of HMO resources from capitated HUSKY rates devoted to marketing, including free ice cream and haircuts, billboards, radio and TV ads, and raffles for school supplies and uniforms, rather than devote similar resources to PCCM marketing, DSS has decided after more than a decade to limit marketing by the HMOs. Marketing guidelines prohibit providers from telling their clients about PCCM, but they can respond to questions about it if asked. To address this contradiction, the advocates purchased and distributed to providers buttons that say "Ask Me About PCCM." We have also produced and distributed hundreds of posters, brochures and FAQs about PCCM for both providers and consumers.

In the absence of DSS' support for the PCCM program, an army of dedicated advocates, interns, students and volunteers has stepped in to recruit providers and inform HUSKY families about the program. It should be noted that in DSS' outreach activities they mention all options available to families, including the three HMOs along with PCCM.



Perhaps our greatest concern is that, despite very low enrollment, DSS intends to go ahead with plans to evaluate PCCM for cost containment among other parameters by July 1st. Any evaluation at such an early stage of a program is unlikely to be valid. A premature evaluation could bias the result and inaccurately label the program a failure before it has a fair chance to reach its potential. We are especially concerned that DSS intends to employ Mercer to conduct the evaluation. Mercer derives a great deal of their business from HMOs across the country and certified the rate setting process that granted the HUSKY HMOs a 24% increase in 2008.

We urge you to build on the significant work by advocates, providers and consumers in generating interest and enthusiasm for PCCM in CT. We urge the General Assembly to:

- Implement PCCM statewide by July 1, 2010. Every HUSKY family deserves to have this option.
- Offer PCCM as an option to HUSKY Part B children, allowing them access to this important alternative to HMOs
- Hire an independent ASO to administer PCCM
 - Advocates and volunteers have devoted enormous time and energy to marketing and accountability in this program. It is time for the state to take responsibility for these functions that DSS is not willing or able to perform.
 - The ASO hired must be completely independent of, and ineligible to become, one of the HUSKY HMOs to ensure that PCCM remains an alternative.
- Remove the irrelevant and intimidating Freedom of Information requirement on PCCM providers.
- Delay the PCCM evaluation until at least one year after at least 20,000 people are enrolled.
 - Any evaluation must be conducted by a truly independent evaluator, with no ties to HMOs or DSS or expectation of future funding, with experience in similar program evaluations.

- Require DSS to conduct a secret shopper survey of each HUSKY program annually
- Commission regular, independent audits of HUSKY program finances
 - A modest investment last year yielded evidence of \$50 million in HMO overpayments
- Create a Special Master for PCCM, appointed by and answering to the General Assembly, to oversee the program if by 12/31/2010:
 - PCCM enrollment is less than 20,000, or less than 500 primary care providers are participating, or the program is not state wide
 - The Special Master must have the resources and authority to independently administer the program. The Special Master must have the authority to override departmental policies when necessary.
 - To avoid even the appearance of conflicting interests, the Special Master must be completely independent of DSS, their contractors, including the HUSKY HMOs, with no financial or other ties in the last ten years.

Thank you for this opportunity to share our thoughts on this critical program for Connecticut families.